Management of Early Pregnancy Failure
SYMPTOM DIARY CODING FORM

Site			Patient No.			Letter Code		Day	

A. IDENTIFICATION

1. Diary date: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ FM12DT
   Month Day Year

2. Day of Week: MON TUES WED THURS FRI SAT SUN DAYOFWK

3. Diary returned Yes (1) No (2) **If No, Skip to Section C.** DIARYRET

B. DIARY RESULTS

1. Bleeding
   None (1) D_BLD
   Spotting (2)
   Light (3)
   Moderate (4)
   Heavy (5)
   More than 2 pads/hr (6)
   Not Answered (7)

2. Number of sanitary pads or tampons used
   D_PADS D_TAMP
   A. Pads ___ ___ B. Tampons ___ ___

3. Passage of tissue D_TISSUE
   Yes (1) No (2) Not Answered (3)

4. Number of pain medication taken
   A. Ibuprofen ___ ___ pills D_IBUPRO
   B. Codeine ___ ___ pills D_CODEIN

5. Episodes of nausea
   ___ ___ times D_NAUSX

6. Episodes of vomiting
   ___ ___ times D_VOMTX

7. Episodes of diarrhea
   (Excluding regular bowel movement)
   ___ ___ times D_DIARX

8. Lower abdominal cramping pain
   ___ ___ . ___ cm D_ABPN

9. Chills? D_CHILLS
   No (1) Mild (2) Severe (3) Not Answered (4)

10. Fever? D_FEVER
    No (1) Mild (2) Severe (3) Not Answered (4)

10A. Temperature __ __ __ . __ degrees F D_TEMP

11. Headache? D_HDACHE
    No (1) Mild (2) Severe (3) Not Answered (4)

12. Tiredness? D_TIRED
    No (2) Yes (1) Not Answered (3)

13. Lightheadedness/dizziness? D_LTHEAD
    No (2) Yes (1) Not Answered (3)

14. Fainting? D_FAINT
    No (2) Yes (1) Not Answered (3)

15. Vaginal intercourse? D_VSEX
    No (2) Yes (1) Not Answered (3)

16. Vaginal douching? D_DOUCHE
    No (2) Yes (1) Not Answered (3)

17. Called a doctor or nurse other than the scheduled study visit? D_MDCALL
    No (2) Yes (1) Not Answered (3)

18. Visited a doctor or nurse other than the scheduled study visit? D_MDVIS
    No (2) Yes (1) Not Answered (3)

19. Went to work or school
    No (1) D_WORK
    < 4 hours (2)
    ≥ 4 hours (3)
    Not Answered (4)

20. Taken other medications? No (2) Yes (1) D_MEDS

Sequence	A. Medication	B. Reason
____ ____ SEQNO	Code: __MEDCODE_____ Specify: ___MEDSP_____ Dose: ___MEDDOSSP_____	MEDREAS
____ ____	Code: ____ ____ Specify:_____ Dose:_____	
____ ____	Code: ____ ____ Specify:_____ Dose:_____	
____ ____	Code: ____ ____ Specify:_____ Dose:_____	
____ ____	Code: ____ ____ Specify:_____ Dose:_____	

CODES

01	NSAID	03	Antibiotic
02	Other Pain Medication	04	Other

C. ADMINISTRATIVE MATTERS

1. Comments: ADD_CMNT _____

   Comments: GEN_CMNT _____

2. Person completing form: CERT_SIG _____ Staff Number: CERT_NO __ __ __ - __ __ __

3. Date form completed: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ COMPL_DT
   Month Day Year